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16 January 2010

How history will remember the last RPSGB president

Exclusive interview page 24

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Group Editor
Gary Paragpuri MRPharmS
01732 377688
News Editor
Max Gosney 01732 377315
Features Editor
Jennifer Richardson 01732 377088
Digital Content Editor
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Reporters
Zoe Smeaton 01732 377441
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Fay Jones 01732 377396
Group Art Editor
Richard Coombs 01732 377528
Designers
David Farram 01732 377120
Jo Konopelko 01732 377231
Office Manager
Elaine Steele 01732 377621
(fax): 01732 367065
esteele@cmpmedica.com
Marketing Manager
Emily Miles 01732 377612
Commercial Director
Ruth McKay 020 7921 8456
Advertisement Managers
Daniel Spruytenburg 020 7921 8126
Deborah Heard 020 7921 8119
Senior Sales Executive
Andrew Walker 020 7921 8123
Online Support Operative
Jonathan Franklin 020 7921 8333
C+D Data
Devi Patel (Operations Manager)
020 7921 8235
Colin Simpson (Price List Controller)
020 7921 8667
Darren Larkin (Electronic Data Controller) 020 7921 8294
Sandra Drawbridge (Input Clerk)
020 7921 8674
Projects Director
Patrick Grice MRPharmS
01732 377296
Training Development Managers
Sara Mudhar MRPharmS
01732 377463
Kinna McConochie MRPharmS
01732 377487
Projects Administrator
Pauline Sanderson 01732 377269
Production Controller
Christine Langford 0207 560 4133
Managing Director
Phil Johnson 01732 377633
Email
firstinitialsurname
@cmpmedica.com

Circulation and subscriptions:
01858 438809

Editor's comment

Profession *definition*: **a body of people in a learned occupation.**

From snow heroics to making a substantive difference to people's lives, the news this week abounds with the professionalism of pharmacists and their teams.

We reveal pharmacists staying overnight in their pharmacies to ensure they would be open the next day and even one superhero who ran six miles in blizzard conditions to keep not one but two, pharmacies open (p6).

And we even manage some celebrity endorsement, with TV's Phillip Schofield singing the praises of Boots staff for rescuing his mother. The stories, which I'm sure are just the tip of the iceberg, demonstrate the dedication that we know is regularly upheld across the pharmacy network. Not for nothing does pharmacy consistently do well in patient satisfaction surveys.

Weather aside, the sector's professional advancement is further evidenced with the news of a pharmacy pilot that has produced a significant improvement in hepatitis detection rates (p7). But perhaps most momentous of all is the news that the first NHS-funded HIV-screening pharmacy service is demonstrating its value by identifying its first patient just three weeks after launching.

But will this professional approach feed through to the new professional body? For this will be at its very heart and the Society of the future will need to cultivate, develop and actively support such forward thinking practitioners, if it is to become the organisation that outgoing president Steve Churton hopes (p24).

Whether his legacy matches his ambitions will, however, depend as much on members' desire to engage with the new organisation as it does on the Society's ability to transform itself into a member-orientated professional body.

Ultimately, the new professional body will only be as good as we make it. So it's disappointing that the last president of the RPSGB reveals in a frank interview the propensity of some members not to accept and embrace change as his greatest frustration.

Like many other pharmacists, the Society of old was not one I particularly wanted to join. I can recall an incident as a newly qualified pharmacist when I needed help. I rang the RPSGB's information department for advice. The response was polite but utterly useless. I never bothered again.

But the professionalism shown by pharmacists these past weeks in such difficult circumstances should not be wasted. Opportunities to re-create a professional body rarely arise, and we should not squander the chance to shape it into the leadership body we deserve. Voting in the elections is a must.

Gary Paragpuri, Editor

> "OPPORTUNITIES TO RECREATE A PROFESSIONAL BODY RARELY ARISE, AND WE SHOULD NOT SQUANDER THE CHANCE TO SHAPE IT INTO THE LEADERSHIP BODY WE DESERVE"

News

Features

Snow heroes defy the white out

Pharmacists go extra mile to keep patients supplied with medicines despite snow

John Tucker ran six miles to open stores

Chris Chapman
cchapman@cmpmedica.com

Pharmacists have gone above and beyond the call of duty, including sleeping in their premises and wading through snow on foot, to keep patients supplied throughout the cold snap.

Weldricks pharmacist John Tucker (pictured) ran more than six miles in blizzard conditions to come to the aid of the multiple's Goldthorpe Barnsley Road branch (see 1 on map), whose pharmacist had been left stranded at home. Mr Tucker ran the two-mile round trip three times in one day, ensuring both branches could operate.

He said: "I think in total we managed to dispense to eight methadone patients and dispense around 100 items."

In Devon, Neil Ansell of Bampton pharmacy (2 on map) made the decision to stay in his dispensary after anticipating last week's heavy snowfall. The decision proved justified when six inches of snow fell, rendering local roads impassable, Mr Ansell said.

"The pharmacy was nice and warm, so it was no trouble to stay... I laid down some cushions, and had a radio."

Staff at Boots' Reading train station (3 on map) received thanks from TV presenter Phillip Schofield for their part in battling the arctic weather. The star posted on Twitter to praise the pharmacy after they rescued his mother from the cold.

Mr Schofield said: "Thanks to the lovely staff in Boots at Reading station who gave my very chilly mum a chair and pointed a heater to defrost her. Love Boots."

Pharmacist Gary Jones, of Borth Pharmacy in Wales (4 on map), had to resort to making deliveries in a Land Rover after the icy roads proved too treacherous. The pharmacy had been reduced to only one member of staff and a pharmacist because of the road conditions, Mr Jones added.

Send us your experiences and pictures of the snow to haveyoursay@cmpmedica.com

Burst pipes and blocked roads fail to stop services

The arctic blast sent shockwaves through some community pharmacies last week as pipes burst and supplies could not be delivered.

Both Maguire Pharmacy in Belfast (5 on map) and Rowlands Pharmacy in Millom, Cumbria (6) told C+D they had suffered flooding after their water pipes burst in the poor weather.

And road conditions also led to supply problems. Kevin Symonds, of Boots in Mullion, Cornwall (7), said he had been unable to get supplies for two days.

However, while they acknowledged there had been some service interruption, Alliance Healthcare and Phoenix praised staff commitment. Staff had even slept in depots after being left snowbound by poor road conditions, both wholesalers said.

According to the Met Office, the pharmacy hardest hit by the weather was Davidsons Chemist in Aberfeldy, Scotland (8). However, pharmacist Mark Jenkins said the pharmacy had managed to maintain services despite 40cm of snowfall. **CC**

For more examples of pharmacies overcoming the weather around the UK, go to www.chemistanddruggist.co.uk

DH praises pharmacist efforts

The government has praised pharmacists for their dedication to patients during last week's heavy snowfall.

In a statement to C+D, the Department of Health (DH) singled out pharmacists for their efforts during the subzero conditions.

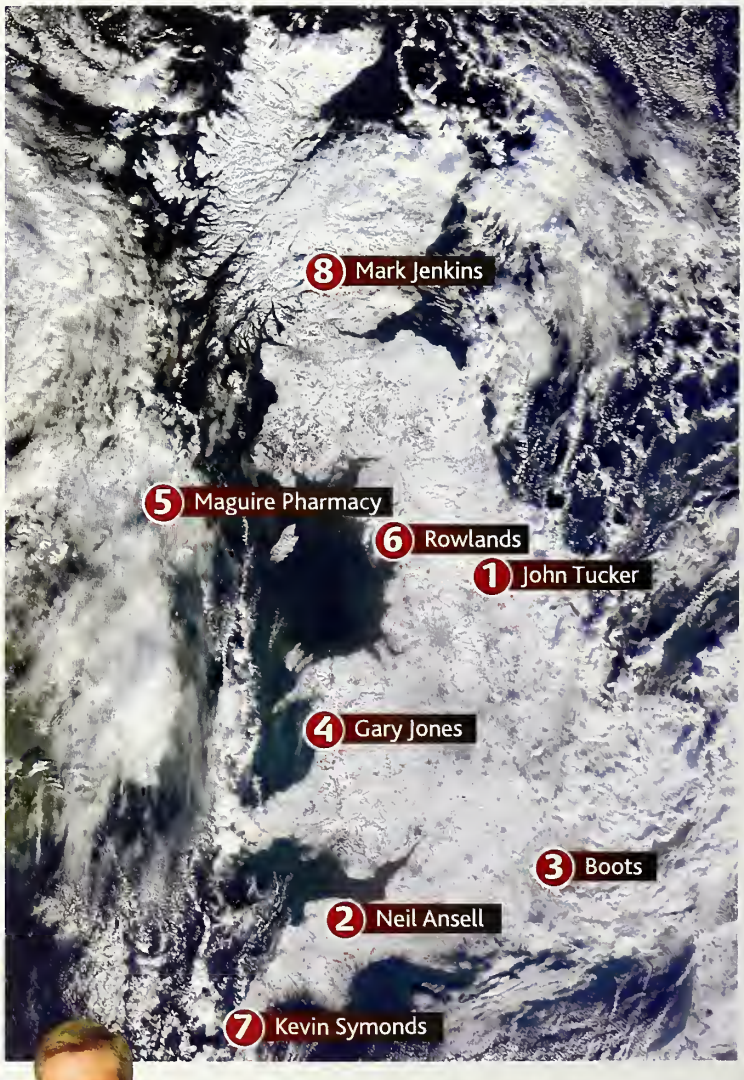
It said: "The government is very grateful for the efforts made by everyone in the NHS, including pharmacists, to ensure that people continue to get the treatment they need during the current cold spell."

The praise was echoed by NPA chief executive John Turk, who described pharmacy staff as "remarkably resilient".

"Pharmacists and other pharmacy staff are once again proving themselves to be the unsung heroes of Britain's high streets," Mr Turk added.

The RPSGB reassured pharmacists concerned about possible breaches of responsible pharmacist regulations, stating inspectors would consider the adverse weather when assessing any infringements.

"As far as we are concerned, this will be looked at as an untoward incident, and will be looked at on a case-by-case basis," a spokesperson added. **CC**



Why we should celebrate remarkable snow stories. Read the NPA chief's view at:
www.chemistanddruggist.co.uk

Staff must wait on new year pay rise decisions

Biggest employers won't decide until later this year

Kathy Oxtoby/Emma Wilkinson

Pharmacy staff working for the big national multiples have been left waiting to hear if they will get a pay rise this year.

However, colleagues at independent pharmacies are being rewarded with bonuses and salary rises, a snapshot survey by C+D has revealed.

Paul Stretton, head of recruitment at Boots, said "no decisions on overall increases" had been made for 2010-11. "These are set following our financial end of year," he added.

Lloydspharmacy has yet to make a decision, but in line with previous salary reviews any pay rise is unlikely to be until October 2010, the firm said.

John Nuttall, managing director of Co-operative Pharmacy, said a final decision on pay had not been reached.

Other large pharmacy chains, such as Rowlands and Sainsbury's, declined to disclose details on pay.

However, independent multiple Day Lewis did commit to an increase.

Kirit Patel, managing director at the group, said although from an economic point of view a pay rise was not justified, his staff had worked hard to manage a rising workload and not to give them a pay boost would be "unreasonable".

Smaller independent pharmacies approached by C+D said they were planning to give their staff pay rises in 2010 despite difficult economic circumstances.

Independents that C+D spoke to in London, Norfolk and Hertfordshire said staff had received pay rises up to as much as 10 per cent above the rate of inflation. Employees had also received Christmas bonuses ranging from a week to three weeks' salary.

Stephen Foster, pharmacy superintendent at Pierremont Pharmacy in Broadstairs, Kent said they were considering plans to write performance-related pay into the staff contracts.

Pharmacy hepatitis pilot trumps GPs' surgeries in spotting sufferers

Pharmacists have hailed the success of hepatitis testing in community pharmacies after a pilot revealed higher detection rates than in GP surgeries.

The three-month pilot, which involved 19 pharmacies across five PCTs, detected hepatitis C in 35 and hepatitis B in four of the 234 patients tested – a detection rate of 15 per cent and 2 per cent respectively.

The results compare favourably with screening in GP surgeries, where only 4 per cent of tests are positive for hepatitis C and 2 per cent for hepatitis B.

The pilot results demonstrated pharmacy's accessibility to patients, said PSNC head of NHS services Alastair Buxton. The test could be combined with others such as chlamydia and HIV screening to provide a "more comprehensive sexual health service" in the community, Mr Buxton suggested.

However, he added that while he had "no objection" to a national rollout, the test was "pretty innovative" and a greater evidence base was needed.

The test was straightforward and helped detect patients who had slipped through other screening services, said Francisco Alvarez, of Regent Pharmacy on the Isle of Wight. The pharmacy had continued to offer the test after the pilot ended, combining it with HIV screening already commissioned by the PCT, Mr Alvarez added.

Pharmacists were paid around £10 to £15 per patient by the PCTs involved in the scheme, which included free training by The Hepatitis C Trust.

In December the Health Protection Agency said hepatitis C rates were increasing, with more than 8,000 new cases in 2008, up 6 per cent on 2007. **CC**

Pharmacy test picks up HIV-positive patient

The first HIV-positive patient to be identified by NHS-funded pharmacy screening has praised the profession's role in improving his prognosis.

Just three weeks after PCT-commissioned HIV screening was launched in Isle of Wight (IoW) community pharmacies (C+D, December 12, p5), an HIV positive patient previously unaware of his infection was identified. As part of the service the patient was "fast-tracked" into the island's sexual health service and has started treatment.

When asked why he attended a pharmacy for the test, IoW PCT told C+D, he said that his good relationship with his pharmacist was such that he trusted her advice and always valued the service and support he received.

This "demonstrates the value of these services being provided via community pharmacies", IoW PCT community pharmacy lead Kevin Noble said.

"The patient is now in treatment, following rapid referral," Mr Noble added. "He was very positive about his situation and grateful for diagnosis at an early stage as this has improved his long-term prognosis." **JR**

Find out how pharmacists pioneered the HIV tests at:
www.chemistanddruggist.co.uk

In brief

Care records momentum

Pharmacies should be made part of the summary care record programme "relatively quickly", as momentum builds to get the records rolled out, Connecting for Health group programme director Tim Donohoe has told C+D. See page 12 for the full interview.

Varenicline services

Fife pharmacists are set to pilot two NHS smoking cessation services, including independent prescribing of varenicline. Eleven pharmacies will take part in the pilot, which is funded by the local health board and due to last three months.
www.chemistanddruggist.co.uk

Counter fraud focus

An NHS counter fraud service (NHS CFSMS) exercise asking contractors to send MUR forms to PCTs has been halted, but the organisation is still working with PSNC and NHS Employers to see how pharmacy services could be redesigned to reduce fraud.
www.chemistanddruggist.co.uk

Adherence progress

The DH has not fulfilled white paper pledges on work to improve medicines adherence, but advancements are still being made on developing pharmacy's role in the area, said PSNC.
www.chemistanddruggist.co.uk

CMS 'still in negotiation'

Scottish pharmacists are still negotiating the long-term conditions service described as "the jewel in pharmacy's crown", Community Pharmacy Scotland has said. The confirmation came after the Scottish Government published a "generic framework" report for the chronic medication service (CMS).
www.chemistanddruggist.co.uk

Christmas retail rise

Retail sales rose over 4 per cent in December against the previous year, the British Retail Consortium has reported. Toiletries and cosmetics "picked up" it said, and winter skincare showed "some gains". Cough and cold remedies "fell back" and "antibacterial products levelled out".

Chlamydia campaign

The government has launched a campaign to increase chlamydia screening in 16 to 25-year-olds. The DH initiative includes TV adverts and a website at: **www.nhs.uk/worthtalkingabout**

NCSO endorsement

The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for the following items for January prescriptions:

- diltiazem 60mg modified release tablets
- pseudoephedrine 60mg tablets.

Motilium 10 update

Motilium 10 (10mg domperidone) is now indicated for the "relief of nausea and vomiting of less than 48 hours duration", which can be associated with over-indulgence, migraine, period pain, or stress.

Axorid launch

Ketoprofen and omeprazole are now available as a POM combination therapy, Axorid. The formulation is licensed for the symptomatic treatment of rheumatoid arthritis, ankylosing spondylitis and osteoarthritis in patients at risk of developing NSAID-associated GI ulcers in whom continued treatment with ketoprofen is essential.

Conference details out

This year's Community Pharmacy Conference will focus on changes to the pharmacy contract and on the importance of getting PNAs right, PSNC has announced. **www.chemistanddruggist.co.uk**

Script charges fall

The prescription charge in Scotland will fall from £4 to £3 in April if the Scottish Parliament approves regulations laid before it last week.

Lloyds chief attacks 'archaic' rental contracts

EXCLUSIVE Quarterly fees putting the squeeze on pharmacies, says MD

Jennifer Richardson
jrichardson@cmpmedica.com

Lloydspharmacy chief Richard Smith has slammed landlords' use of "archaic principles" for rental contracts.

The multiple has backed retailers' calls for more flexible terms, particularly the scrapping of quarterly advances in favour of monthly payments.

The British Retail Consortium (BRC), which Lloydspharmacy joined in November, said quarterly rental terms were "an unjustifiable practice" with "no place in the modern age".

But a BRC survey carried out last month found just one in eight retail property leases were on monthly terms, which it described as "shameful".

The problem was particularly acute for community pharmacies, said Mr Smith, as their value was going down due to category M as costs were rising.

Richard Smith: more flexibility needed

He said: "The government doesn't pay us for three months, the landlord wants his money three months in advance – that's a six-month gap in the numbers."

Lloydspharmacy had tried to renegotiate some terms, Mr Smith added, but it was difficult because it had "virtually thousands of contracts".

NPA chief executive John Turk said it "naturally supported" calls for landlords to offer flexible terms, to improve cash flow management – which was "always important, but especially so when pharmacies are operating within a fragile UK economic environment".

Independent Pharmacy Federation chairman Fin McCaul agreed monthly rental terms would be "ideal".

Next week: property law expert Philippa Aldrich on how to handle your rent review

PSNC moves to protect incomes

PSNC has stepped up efforts to protect contractor incomes, after the government confirmed PCTs will gain control of pharmacy funding from April.

The 2010-11 NHS Operating Framework, published in December, confirmed that the £1,648 million global sum will be devolved to PCTs from the upcoming financial year.

PSNC head of finance Mike Dent admitted the devolution could be "a massive problem". "We have been trying to stop it but the train is going now, it's not something we can derail," he said.

The contract negotiator was now working with the DH on "very strong deterrents" to prevent PCT actions that might adversely impact contractor incomes, Mr Dent said. He could not provide details while negotiations were ongoing but said an announcement was imminent.

PSNC has previously warned against the potential for PCTs to "manipulate" funding, such as issuing longer prescriptions to reduce practice payments (C+D, October 13, 2007, p10).

The global sum will continue to be set nationally by PSNC/DH. **JR**

End of road for College of Pharmacy Practice

The College of Pharmacy Practice (CPP) is to become part of the professional leadership body (PLB), its chief executive Ian Simpson has confirmed. The move is expected when the PLB is launched in April.

About 800 members and fellows of the CPP have been informed by letter of plans to dissolve the organisation and they have been reassured that its accreditation activities will be moved to the PLB.

The College has agreed that its conferences and symposia will be taken on by the PLB.

Based in Coventry, the CPP office will close on March 31. No membership fees will be collected after this date. All four staff at the Coventry office will be made redundant. **KO**

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Reference: 1. National Institute Clinical Excellence. Smoking cessation services in primary care, pharmacies, local authorities and work places, particularly for manual working groups, pregnant women and hard to reach communities. Public Health Guidance 10. February 2008.

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Read the MHRA proposals in full at www.chemistanddruggist.co.uk

Dispensary talk

What was the best decade to be a pharmacist?

"For me, the best decade was the 1990s, because that's when pharmacy really started to get somewhere. There was national recognition of the potential for pharmacists to extend their role."
Linda Bracewell, Baxenden Pharmacy, Accrington

"I qualified in the 1980s. For me this was the best time as it seemed to be a more relaxed world. Since then the volume of work has increased massively without a corresponding increase in staff."
Andrew Mawhinney, Lloydspharmacy, Torquay

Web verdict

The 2000s 13%
The 1990s 21%
The 1980s 29%
The 1970s 16%
The 1860s 21%

Armchair view: It's one of the closest fought polls ever, but bring out your Spandau Ballet LPs and shoulder pads as the 1980s is officially crowned the golden decade.
Next week's question: Will you be voting in the RPSGB elections for national pharmacy boards? Vote at **www.chemistanddruggist.co.uk**

Industry slams parallel trade clampdown bid

Limitations could restrict legitimate practices, warns NPA

Zoe Smeaton
zsmeaton@cmpmedica.com

Experts have warned that MHRA proposals to further restrict the trading of medicines between pharmacies are unnecessary and could hamper pharmacy practices.

The MHRA has suggested limiting inter-pharmacy trade in the absence of a wholesale dealer license to emergency, not for profit, instances, in a consultation (MLX 365) published last month.

The agency said this would "have the effect of limiting unregulated inter-pharmacy trade, which will also limit the opportunity for counterfeit medicines to enter the legitimate supply chain".

But Gareth Jones, the NPA's NHS liaison manager, warned: "The proposals could significantly restrict legitimate and long established pharmacy practices, such as selling stock to other pharmacies (to resolve local stock shortages) and GP surgeries." The NPA board will consider the issue in full, and the association will express reservations to the MHRA, he added.

David Reissner, head of healthcare at law firm Charles Russell, questioned how restricting transfer of medicines between pharmacies would reduce counterfeit medicines entering the supply chain. "Transfer between pharmacies is recycling the product whether it is a counterfeit medicine or not," he said. The proposal was not doing what it said on the tin, he added. Mr Reissner encouraged pharmacists to respond to the MHRA's consultation, which ends on March 12.

The consultation features a number of measures designed to beef up supply chain security, such as a "fit and proper person" test for those applying for a wholesaler dealer licence.

Local exchange of medicines without wholesale dealer licenses would be allowed only when occasional, in small quantities (ie to meet an individual patient's needs) and not for profit.

MHRA proposals to tackle parallel trade

- Limit parallel trading between pharmacies without wholesaler dealer licences (WDL)
- Consider capping parallel trading without a WDL to no more than 5 per cent of the total retail trade in licensed medicinal products at the registered pharmacy
- Introduce targeted inspections
- Establish the real size of the parallel trade through pharmacy and launch an impact analysis on changes to rules governing wholesale activity

Society 'too late' backing three-year rule change

Industry analysts have backed RPSGB calls to remove rules stopping EU qualified pharmacists running new pharmacies, but called the Society's efforts too little, too late.

Under UK law, EU qualified pharmacists may not act as responsible pharmacists unless the pharmacy premises have been registered for more than three years. But now the RPSGB has led other pharmacy bodies in lobbying the Department of Health for the rule to be removed.

The move comes too late for French locum Dr Fosso Taga, who last year challenged the rule in the European Parliament (C+D, October 3, 2009, p8). He said: "I don't really know what is going on, the Society was an interested party in my case but never supported me and now all of a sudden they come out of nowhere and say this."

The Society said it could not "support" Dr Taga because as the regulator at the time it had a statutory duty to enforce prevailing legislation. On timing it said the issue had been "partially brought back into focus due to the responsible pharmacist rules while at the same time the DH indicated a willingness to consider this matter if all pharmacy bodies were in agreement".

David Reissner, head of healthcare at law firm Charles Russell, backed the Society's decision but added: "The three-year rule has never had any sort of justification, but this is an issue I took up with the Society several years ago." **ZS**

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EPS: are we nearly there yet?

EPS has been hit with delays and viewed with increasing scepticism from pharmacists. **Zoe Smeaton** puts Tim Donohoe, the man in charge of the project, on the spot

The electronic prescription service (EPS) has had its fair share of bad press – delays, the refusal of pharmacy bodies to back it and accusations that it has stifled developments in pharmacy IT.

Project lead Tim Donohoe now says pilots of release 2 (in which pharmacies receive live prescriptions electronically from GPs) are moving forwards though and that he expects pharmacy systems to be ready for rollout this spring. But are things really looking up for the apparently ill-fated service?

Mr Donohoe says he sympathises with pharmacists who are sceptical. "One of the issues we've undoubtedly had is that this has been a long time coming," he admits. But he says if time taken means we end up with a system that works, "then that will be a very good thing".

Whether the systems will in fact work continues to be a topic of much discussion. But Mr Donohoe is defiant and says there would be "absolutely no benefit" to Connecting for Health (CfH) from delivering something that doesn't work. "And by doesn't work I don't mean you switch it on and it doesn't work. I mean if pharmacists can't make good use of it, if it doesn't make their working environment better, then we will have failed," he says.

A particular disappointment on this topic for CfH has been the refusal of the NPA, PSNC and the RPSGB to back EPS until pilots have been completed. The pharmacy bodies say they need to see evidence that the system works. And the NPA is so concerned that EPS must be fully tested that it is now planning to submit a proposal to CfH detailing how it thinks the pilots should be carried out.

Suppliers including Cegedim Rx back CfH, saying it is already testing the systems fully, and while Mr Donohoe says he will consider any proposals offered, he is quick to defend the project: "We haven't just plucked the idea of EPS out of the air... the system suppliers wouldn't let us get away with saying let's do something that's completely off the wall with no evidence to back up that it would work."

"If [EPS] doesn't make [pharmacists'] working environment better then we will have failed"

TIM DONOHOE, EPS PROJECT LEAD, CfH

Mr Donohoe also dismisses rumours that pharmacy systems now being tested might not all be designed to the same rigorous CfH specifications. "If we put out a system with which there are problems, that's going to damage the reputation of the project... people can be assured that when systems are available for national deployment they will be absolutely fit for purpose."

So how are the pilots going, and what about stories that GPs have not been happy with their systems? Mr Donohoe plays down the problems and says functionality issues identified so far have been addressed. "Far better to trap that at the first site than to have it roll out to a few thousand users and then find out that actually it is not right."

Quite when that rollout might be completed still seems unclear, but Mr Donohoe concedes that by the end of this year he doesn't think everyone will have EPS release 2. Yet he remains positive that pharmacy will be further forward than most, with pharmacy systems likely to be ready before GP software.

And overall he remains upbeat. "I put my faith in the fact that the pharmacists we talk to at an individual level in general are much more positive [about EPS] when they see the system." He says such engagement with pharmacy happens at "different levels", citing formal meetings with the pharmacy bodies and user groups, but also "informal ones, [with] all the people we talk to and all the people the system suppliers talk to".

Benefits of EPS will include the ability to download repeat prescriptions overnight, he says, which could potentially help with workload planning. And he says: "I think as people become familiar with it, they will become more comfortable with the ideas and I remain confident that the benefits of EPS will lead to its adoption willingly."

He is also positive about the benefits EPS could bring pharmacy systems, dismissing accusations from last year's review of NHS IT, commissioned by the Conservative Party. This suggested that EPS had stifled IT development as suppliers focused development work on the project, but Mr Donohoe says: "I think it's debatable whether that's actually true and I think potentially where we have got suppliers to in terms of interoperability, incorporating the NHS number and so forth, gives them a springboard to do some exciting things with their systems going forward."

Rapid thyroid test kit for pharmacy

Tyrrell Healthcare is introducing a thyroid function testing kit as an additional screening service for pharmacies.

ThyroScreen Professional is a rapid blood test for the thyroid stimulating hormone. Manufactured by Pathway Diagnostics, the test takes 10 minutes to display a reading.

Tyrell Healthcare says the test can drive increased revenue from MURs, pointing out that if the tests are charged at £20 each, it will give the pharmacy a profit of more than £215 for 20 tests.

Price: £125/20 tests (equivalent to £6.25 per test)
Tyrrell Healthcare
Tel: 01273 49440

Market focus

- Thyroid dysfunction tests are the fifth most requested lab test by UK doctors, yet only 20 per of sufferers have been identified.
- Under-active thyroid affects almost 10 per cent of women and 2 per cent of men in the UK.
- Four out of five women remain undiagnosed and continue to suffer a wide range of non-specific symptoms.

Baby Nose-Clear now on prescription

The Baby Nose-Clear Nasal Aspirator has been given prescription status and is on the Drug Tariff from this month.

The class 1 medical device is designed to clear babies' noses to allow clearer breathing, easier feeding and restful sleep.

It physically removes mucus, which helps prevent secondary complications such as coughs, stomach upsets and ear infections.

Using controlled mouth suction with a filter, parents can target visible mucus with the nozzle and gently suction mucus into the device.

Paediatrician-approved for use from birth, the device is useful as a tool for mums who are struggling to breastfeed due to their baby's blocked nose.

Invented by a mother of premature triplets, the CE marked device won the Queen's Award for Innovation in 2008.

It can be washed in warm soapy water and reused but should be sterilised between infants.

Price and Pip code: £6.99, 301-9452
4FX Healthcare
Tel: 01623 827945

Deep Heat's winter warmer

Mentholatum is supporting Deep Heat with a £1 million TV advertising campaign running from January 18 until Valentine's Day.

The eye-catching ads feature the glowing outlines of people playing golf, tennis and dancing while using Deep Heat Patch and Deep Heat Patch for Back Pain.

The voiceover is by Anna Chancellor (Duckface in the film Four Weddings and a Funeral), inviting viewers to 'feel the Deep Heat heat' and explaining that with the patches 'you've got pain covered'.

"This is the time of year when people complain that they notice their aches and pains more and the recent freezing spell puts people at greater risk of slipping and tweaking muscles and joints," says Lynn McGinness, senior brand manager at Mentholatum.

Laser Healthcare
Tel: 01202 780558

P&G signs leading dentist

Procter & Gamble has teamed up with well known cosmetic dentist Dr Phil Stemmer, who will represent the Oral-B brand as its spokesperson.

Dr Stemmer will work alongside the company for the next year to highlight the simple measures consumers can take to maintain good oral health. Founder of the Fresh Breath Centre in London, he has acted as a consultant for many organisations including the British Dental Association and the BBC.

Jo Buckley, oral care business leader at Procter & Gamble, comments: "We're delighted to be working with Dr Stemmer as an ambassador for Oral-B. He will help to heighten awareness of our campaigns and the importance of achieving and maintaining good oral health through the use of quality products and simple techniques."

Procter & Gamble
Tel: 01932 896000

Xrayser

Snow and ice, but the show must go on

> DESPITE ILLNESS, FLOOD, FIRE OR THE RECENT SNOW AND ICE, YOU CAN GUARANTEE YOUR LOCAL PHARMACY IS OPEN

I shouldn't be in the pharmacy today, but my locum phoned at 7.30am to say he was snowed in. I cursed as I got out of my warm bed, but to be fair it's only the second time in 10 years he's not come in for any reason, and of course that's how it is in pharmacy – the show must go on.

The P&G give very cheap income protection for pharmacists – especially pharmacy owners – because they know that we're not the sort of people who decide a sniffle means we need "a day in the warm". So, despite illness, flood, fire or the recent snow and ice, you can guarantee your local pharmacy is open – even if I did need my shovel to clear the snow and ice, and then also from under the wheels of a stranded motorist across the road. "Cheers mate!" he calls as he edges slowly off.

So this made it all the more galling to receive a message from the PCT reminding us of the contractual requirement to open, and that closure was not acceptable to the NHS. This was sent by a PA, no doubt working from the comfort of her home, while the hardest journey most PCT managers are having is to and from the coffee machine. It also brings to mind the ever present arguments about 'continuity plans'. Over the years we have had IRA bombing campaigns, fuel shortages, heat waves, floods, terrorists, and pandemic flu, as well as the current snow and ice, so the only thing missing from my continuity plan is martian invasion or zombie attack. That, and producing another locum at short notice. So here I am, along with all bar one of my staff. The open pharmacy is proof that our continuity plans work, and all we lack now are patients – because hardly anyone is bothering to come out!

For a while here the girls sit around swapping travel stories to rival Ben Fogle, and I try to decide if I'm going to review a risk assessment or suggest a game of online chess with a local GP. Conscience tells me this is that 'moment's peace' I am always begging for, when I hear the pharmacy technician reassuring a patient that we are open, and we ordered his morphine from the local wholesaler as we knew they could get through. "What would we do without you?" I heard – for the second time that day – and I thought about the antibiotics, Tamiflu, and other prescriptions we'd dispensed.

How easy to forget that our job is really important for the patients who had struggled out to us. Even the PCT has relented, with another message saying they have "had extremely helpful co-operation from pharmacies" and were "impressed at the continuity planning". Of course, that's how it is in pharmacy – the show must go on.

Richard Smith

Will 2010 be a good year for pharmacy?

A precarious financial situation, a likely change of leadership and a series of seemingly impossible choices. I could be talking about Britain in 2010 or about pharmacy in the year ahead. Take your pick.

2010 will be a pivotal year for pharmacy. The cost inquiry promises to shed new light on the realities of providing first class community pharmacy services and to set a new framework for contract negotiations.

But data alone will not win the day. In politics, personalities and PR are at least as important as facts and figures. That is something GPs understand well. The influence they are able to exert within the corridors of power is humbling. It is enabled by strident voices and a unified professional leadership. We can learn much from their example.

At a recent conference for PCT medical directors, I laid out the cost savings if all minor ailment consultations were moved into community pharmacy and out of doctors' surgeries. The sums certainly add up. The average GP consultation costs the taxpayer £32. The same consultation with a pharmacist costs £17.75.

If all minor ailments were channelled into pharmacies, the sector could generate an incremental £4.5 billion over the next five years and save the exchequer billions.

Yes, say the medical directors, but I still have to pay GPs whether they treat these patients or not, whereas I only have to pay pharmacists per intervention.

And there you have it: a contract for GPs that provides huge insulation from the vagaries of the marketplace and another for pharmacists which is governed fairly and squarely by the laws of supply and demand.

Why is pharmacy still a Cinderella service despite the manifest value (and value for money) we are able to deliver?

I don't pretend to have all the answers but the year ahead will be make or break for the profession. With almost £180bn of debt and deep public spending cuts a certainty, pharmacy stands at a crossroads. In one direction lies an existence on the margins of healthcare, in the other a future in which pharmacy is freed to improve the health of the communities it serves while delivering huge cost efficiencies to the NHS.

The direction we take is only partly dependent on statistics and analysis. Leadership and conviction are important too.

Richard Smith is managing director of Lloydspharmacy

> IN ONE DIRECTION LIES AN EXISTENCE ON THE MARGINS OF HEALTHCARE, IN THE OTHER A FUTURE WHERE PHARMACY IS FREED TO IMPROVE HEALTH

C+D Pharmacy forum

Flomax Relief – a new treatment

Flomax Relief (tamsulosin HCl 0.4mg) is a new 'POM to P' over the counter treatment for the urinary symptoms of benign prostatic hyperplasia (BPH). It is indicated for treatment of the functional urinary symptoms of BPH (see panel) in men aged between 45-75 years.

Key features

- Alpha$_1$ blocker – so a first line treatment for BPH[1]
- Contains tamsulosin, the UK's most widely prescribed drug for BPH[2]
- Relief of symptoms of BPH within one week of treatment[3]
- Taken as a once daily dose (one capsule), ideally after the same meal each day, with no dose titration required[4]
- Few drug interactions[4] associated with tamulosin and side effects are few and generally mild[5-7].

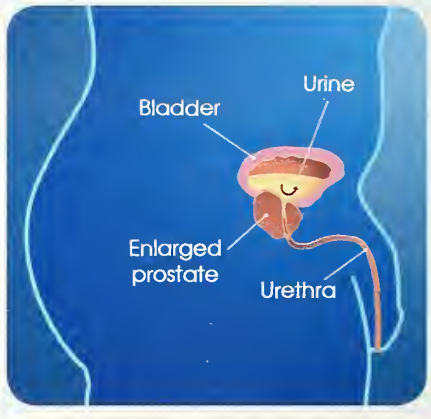
The urinary tract symptoms caused by BPH may initially be an inconvenience, but can become more debilitating as the condition progresses. Some sufferers are unwilling to leave home without knowing where the next toilet will be, with a consequent impact on social activities. Sleep patterns may also be disrupted.

Alpha$_1$ blockers such as tamsulosin are a first choice treatment for men with smaller prostates and moderate/severe lower urinary tract symptoms (LUTS). They work by relaxing the smooth muscle in the prostate and bladder neck, thereby allowing an increased maximum urinary flow rate and providing symptom relief. The National Institute for Health and Clinical Excellence is due to publish guidelines on the management of LUTS in 2010.

Benign Prostatic Hyperplasia

BPH is a common condition in men that can lead to lower urinary tract symptoms. Around 1 in 4 of men over 40 experience some symptoms of BPH, yet – in one study – 89% of men with the condition didn't consult their GP in the year before the study began.[8]

BPH is a progressive enlargement of the prostate gland, which lies beneath the bladder and surrounds the urethra. It is usually the size of a walnut, but enlargement results in pressure being put on the urethra where it passes through the gland.



This narrows the urethra and obstructs the flow of urine from the bladder causing lower urinary tract symptoms (LUTS). In addition, the muscles of the bladder wall may thicken and this loss of elasticity may reduce the volume of urine it holds.

Urinary symptoms of BPH

Symptoms due to BPH are classified as:

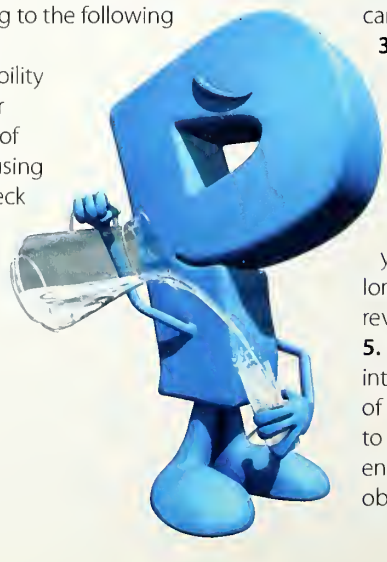
- Obstructive - symptoms related to emptying of the bladder, typically incomplete emptying, intermittency, and straining.
- Irritative - symptoms related to filling of the bladder, typically increased frequency, urgency, and nocturia.

The International Prostate Symptom Score (IPSS) is used to grade LUTS as mild moderate or severe.[9] It is not a diagnostic tool but is valuable for assessing the impact of symptoms on an individual. It has been incorporated into the Symptoms-check Questionnaire (SQ) to help you determine whether a customer will benefit from treatment with Flomax Relief.

How should pharmacists supply Flomax Relief?

Pharmacists should supply Flomax Relief according to the following steps:

1. Assess suitability of customer for initial supplies of Flomax Relief using Symptoms-check Questionaire (SQ).



2. Make an initial supply 2 weeks of Flomax Relief, and advise the customer to see their GP in the next 6 weeks to confirm that treatment can continue.

3. Up to a further 4 weeks' supply can be made, during which time the customer must visit their GP to confirm suitability for long-term OTC treatment, if they have not already done so.

4. Once the GP has confirmed that the customer is suitable for long-term treatment, you can continue to supply Flomax Relief long-term. The customer should be advised to revisit their GP every 12 months.

5. Review symptoms with customer at regular intervals when making subsequent supplies of Flomax Relief in order to monitor response to treatment. Customers should be strongly encouraged to return to the same pharmacy to obtain subsequent supplies.

in association with FLOMAX relief® MR

for BPH

"I have problems peeing..."

"I'm always getting up in the night to go..."

"I worry that I'm not going to make it to the loo..."

"It's so annoying, I have to push to get the pee out..."

"My pee starts and stops..."

Help men take control of the symptoms of BPH with Flomax Relief

Benefit from an extensive consumer campaign raising awareness of BPH and Flomax Relief – £5 million on above-the-line advertising

Support tools

1. Each pack of Flomax Relief will carry a Men's Health Booklet with information on prostate health. There is a registration card at the back of the booklet that should be used to record the treatment start date.

2. Healthcare professional website – www.flomaxrelief.co.uk/hcp – contains information and downloadable BPH management tools.

... and finally ...

Don't forget men may be reluctant to discuss potentially embarrassing health issues, so approach the topic of LUTS and BPH sensitively and discreetly. As medicines counter staff are usually the first point of contact for customers, ensure they are aware of Flomax Relief as a new OTC treatment and the requirement to refer potential customers to a pharmacist.

When not to recommend...

1. Urgent medical referral required if:

- Pain on urination
- Fever (unexplained fever could indicate UTI)
- Bloody or cloudy urine in last 3 months (could indicate possible UTI)
- Urinary incontinence (could indicate chronic outflow obstruction of the bladder)

2. Contraindications to OTC supply

- Prostate surgery undertaken
- Unstable or undiagnosed diabetes (eg characterised by excessive thirst and tiredness)
- Problems with liver, kidney or heart
- Fainting, dizziness or weakness when standing up (postural hypotension)
- Eye operation for cataract planned
- Patient has recently experienced blurred or cloudy vision that has not been examined by a GP or optician
- Allergy or bad reaction to tamsulosin

3. Not to be supplied if customer is:

- Already prescribed treatment for BPH (including prescribed tamsulosin)
- Taking concomitant medication – doxazosin, indoramin, prazosin, terazosin, verapamil

See over page for references and product information

For more information, please visit www.flomaxrelief.co.uk/hcp

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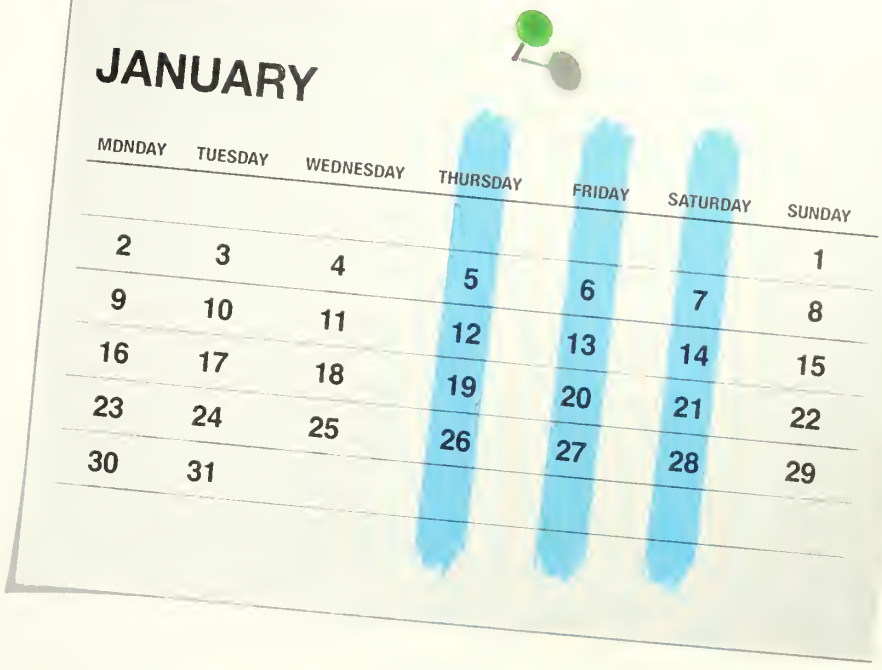
Features



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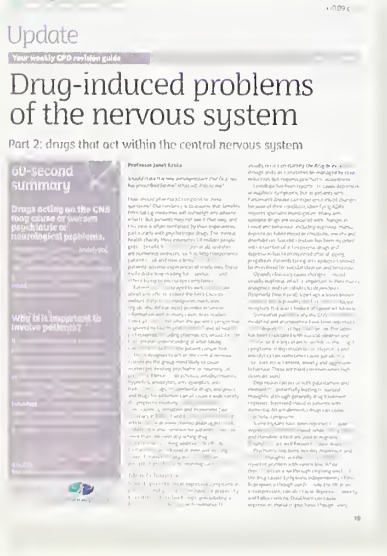

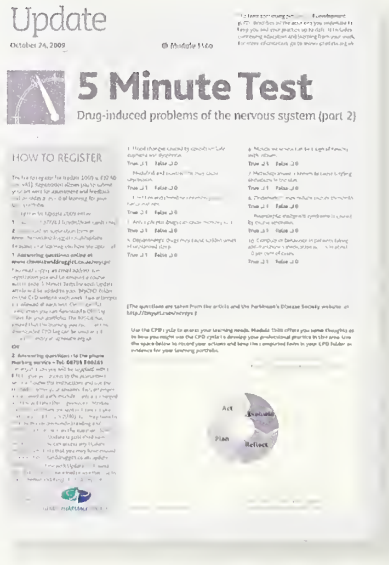

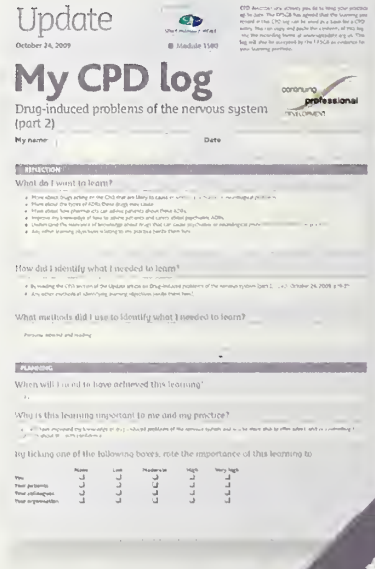

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Update

Your weekly CPD revision guide

Module 1509

Your guide to stoma care

The first of two articles looks at why and how a stoma is formed

Julia Williams

60-second summary

This article, which can be used as part of your CPD, will help you to understand what stoma surgery involves and what patients can expect afterwards.

What prompts the need for a stoma?

The commonest causes are cancers of the bladder and colon, and inflammatory bowel disease.

What determines whether they are temporary or permanent?

A temporary stoma is usually created to divert faeces away from surgically rejoined intestine or to provide an outlet for faeces if there is an obstruction. A permanent stoma may be needed when a disease or its treatment results in loss of normal bowel or urinary function.

What are ERAs?

ERAs are recovery programmes that use new techniques to speed recovery.

This article (Module 1509) can help in the following CPD competencies: G1a, G1d, G1s, C1f,C3h.
See http://tinyurl.com/68ox7b

Stoma care has evolved over decades in recognition of the needs of patients. Creating a stoma leads to a change in body image resulting in a profound threat to the individual's physical integrity and self-concept, particularly in relation to bodily waste[1] and, for those who have difficulties managing their stoma, adaptation to their new body image can be prolonged.[2]

The pharmacist plays an important role, providing support and information to enable the person with a stoma to remain independent, and so up to date knowledge of stoma care is a necessity. This short series of two articles on the care of colostomies, ileostomies and urostomies is in two parts: part 1 explores the diseases that lead to stoma formation, surgical intervention and stoma types, while part 2 focuses on stoma-related complications and choosing appropriate appliances.

It is estimated that there are 102,000 people with a stoma in the UK[3] and about 13,500 new stomas are formed every year.[4] The most common underlying conditions resulting in a stoma are cancers in the bladder and colon, and inflammatory bowel disease. Described as an artificial opening out into the abdominal wall,[5] a stoma is surgically created to divert the flow of faeces, urine or both, that renders the patient incontinent and needing to wear a stoma bag or appliance. The word 'stoma' comes from the Greek for mouth or opening and is generally classified as colostomy, ileostomy or urostomy.

Stomas can be temporary or permanent. A temporary stoma is most often created to divert faeces away from a surgical anastomosis (where two formerly distant sections of the intestine are joined), thus aiding the healing process, or to provide an outlet for faeces when an obstruction has occurred.

A temporary stoma can be reversed, but a permanent stoma implies that the bowel cannot be surgically reconnected. A permanent stoma may be required when a disease or its treatment leads to loss of normal bowel or urinary function.[5]

Stoma-related diseases and surgical intervention

Colo-rectal cancer is the second most common cancer and there are over 18,000 new cases every year.[6] Colo-rectal cancer occurs as a result of a series of changes known as the adenoma-carcinoma sequence whereby small benign adenomas gradually enlarge and develop malignant changes. National Bowel Screening programmes and the Bowel Awareness Campaign's have increased the general public's awareness of the risks of colo-rectal cancer and, with the advent of genetic screening, knowledge is growing as to how and why this cancer occurs. Treatment varies, however, and a combination of treatment modalities is often recommended which, depending on location and extent of disease, will include stoma surgery.

In this instance a stoma can be temporary, to protect the anastomosis, or permanent, to eradicate disease. Procedures such as anterior resection or Hartman's is performed when the tumour has been located within the colon and a temporary loop ileostomy or colostomy is formed in order to protect the anastomosis and allow healing to take place. On the other hand, cancers located nearer to the rectum and posing a threat to the integrity of the anal sphincter will result in a permanent stoma following an abdominoperineal excision of the rectum (APER).

Bladder cancer is the fourth most common cancer in the UK with over 12,000 new cases diagnosed every year.[6] The cause remains relatively unknown but predisposing factors associated with its onset include smoking, occupational exposure to carcinogens, such as rubber and dye from textile factories, and overuse of some analgesics. Treatment greatly depends on the pathological staging and is likely to include stoma surgery supplemented by chemotherapy and radiotherapy.[5] In this instance the patient undergoes total cystectomy (bladder removal) and formation of an ileal conduit (urostomy) resulting in a permanent stoma.

Inflammatory bowel disease is an umbrella term used to describe ulcerative colitis and Crohn's disease. About one in 500 people in the UK are affected by inflammatory bowel disease[7] and, although symptoms vary greatly between Crohn's disease and ulcerative colitis, at least 25 per cent of all sufferers will come to surgery at some point during their disease trajectory and 5 per cent will have a stoma.[7]

Inflammatory bowel disease is a lifelong chronic condition associated with anxiety and depression. Some consider that, regardless of medical or surgical intervention, cure is not possible as the disease is associated with extra-intestinal manifestations.

For inflammatory bowel disease, stoma surgery can be temporary, permanent or restorative, but this largely depends on diagnosis

and extent of disease. As before, a temporary ileostomy allows time for the anastomosis to heal, whereas a permanent ileostomy attempts to offer a cure.

Restorative procedures such as the ileal anal pouch is offered to those with ulcerative colitis only. Following colectomy, the individual is offered an opportunity to have an internal pouch created from the remaining ileum. This option appeals to some as in the long term there is no need to wear a stoma 'bag' because defecation takes place in the normal manner. As the colon has been removed, the pouch acts like a new rectum storing faeces, so that the patient will pass a porridge-like stool between two and eight times in the day as well as at night.[5] More complications are associated with ileal anal pouch surgery than with stoma surgery, the most common being when the pouch becomes inflamed – this condition is known as pouchitis.

Other conditions associated with stoma surgery include familial polyposis adenomatous, diverticular disease, severe urinary and/or faecal incontinence, neurological disorders such as spina bifida, bowel ischaemia, irradiation damage and congenital abnormalities such as imperforate anus.[5]

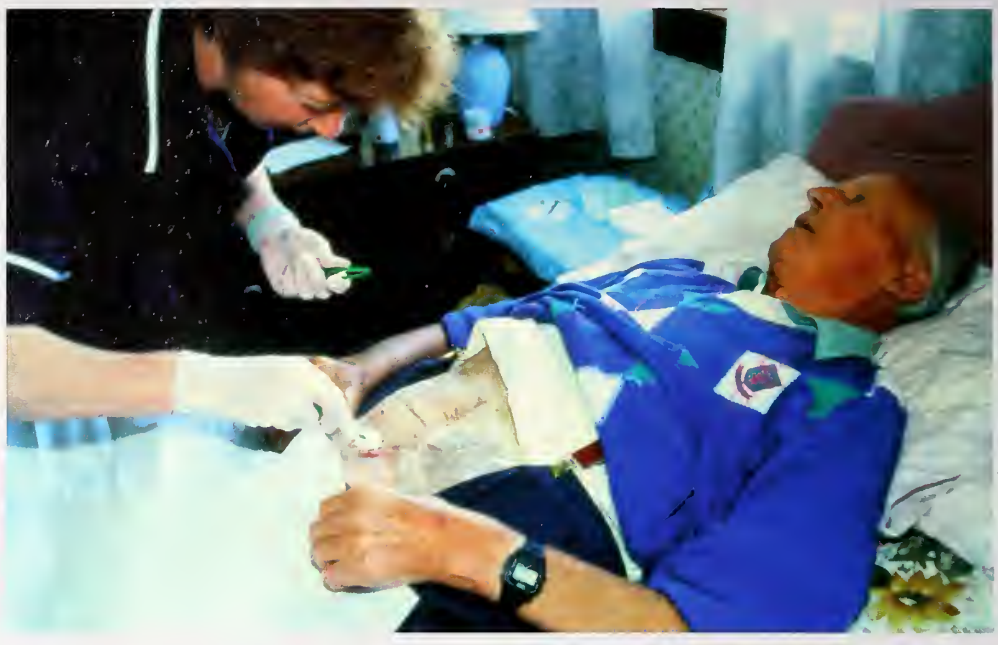
Pre and post-operative stoma care management

The approach to recovery is changing, as enhanced recovery programmes post surgery (ERAS) are increasingly being introduced. ERAS lead to shorter hospital stay because of advances in surgical technique; new pre- and post-operative protocols, including pre-operative fasting, peri- and post-operative analgesics, and early post-operative mobilisation and feeding. There is also a greater emphasis on teaching new stoma patients to become self-caring more quickly.

All patients who about to undergo stoma surgery should be assessed by the stoma care nurse specialist.[8] In the pre-operative period the focus is to prepare the patient psychologically and physically for stoma surgery. The patient is fully informed as to the nature of the procedure. The careful siting of the stoma, whether it is to be temporary or permanent, plays an important role in rehabilitation. A mark is made directly onto the patient's abdomen to show the optimum position of the stoma for that individual, taking the patient's eyesight, mobility, dexterity and general abilities to manage the stoma long term into consideration.

On immediate post-operative examination, the healthy stoma appears red in colour and is warm and moist to touch. The stoma protrudes from the abdomen, although the length varies depending on the stoma type. This is to minimise skin excoriation of the immediate peristomal skin. A typical colostomy should protrude no further than 10mm, whereas an ileostomy and urostomy should protrude to at least 50mm. All stomas are usually either round or slightly oval in shape and the circumference will also vary, averaging between 20 and 40mm.[8]

The type of stoma will determine the nature of the effluent; a colostomist will pass a firm pellet-like faecal stool as the bowel has been diverted from the large colon. Generally brown in colour, the faeces have an odour and will eliminate from the stoma on average once a day. An ileostomist will pass a porridge-like faecal stool as the bowel has been diverted from the small intestine where less absorption has taken place. Generally light tan in colour, the effluent is odourless and will eliminate from the stoma once food is consumed and peristalsis has been triggered.



Antonia Reeve/Sciene Photo Library

The site of the stoma is chosen carefully, taking into account the patient's eyesight, mobility, dexterity and general ability to manage the stoma care in the long term

In a urostomy, a small segment of bowel is used to support the ureters, allowing urine to flow freely. The urine is yellow, straw-like in colour and contains mucosal debris from the bowel. On average, a teaspoon of urine oozes from the stoma every minute.[5]

Practical elements of stoma care, such as changing the appliance, will be taught by the stoma care nurse specialist and reinforced by the nursing staff on the ward. Prior to discharge the patient will have been judged competent in the day to day care of the stoma and will have knowledge of dietary requirements, appliance needs and will be able to recognise potential complications. In some areas the stoma care nurse specialist will visit the patient at home, reinforcing stoma management; elsewhere this is done in the out-patient clinic.

The transition from hospital to home can be stressful,[5] so regular follow-up with good communication is important if patients are to adapt and adjust to their new way of life. Practical aspects of stoma care management are usually picked up quickly but adaptation and adjustment tend to take a little longer.

Many new patients dislike their stoma but over time, with psychological and practice support from all healthcare professionals involved in their care as well as close family and friends, they begin to recognise and accept its purpose. Introducing the new patient to a support network of people in a similar situation can help them more fully appreciate that they are not alone.

Julia Williams, MEd, BSc (Hons), Dip D/N, RGN, is senior lecturer in gastrointestinal nursing at The Burdett Institute of Gastrointestinal Nursing in partnership with King's College London and St Mark's Hospital, Harrow.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.

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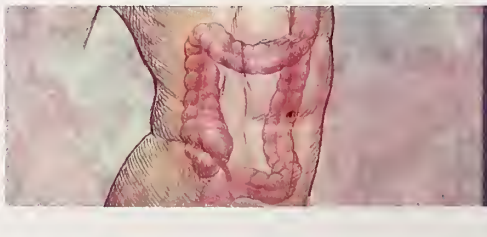

NEXT WEEK
The different types of stoma appliance and when they are used

Your guide to stoma care

Reflect

For what conditions are patients likely to need a stoma as part of their treatment? Why is the siting of a stoma important and what factors need to be considered? What kind of faecal stool would an ileostomist pass?

Plan

This article discusses the conditions that may lead to stoma surgery, such as bowel and bladder cancer and inflammatory bowel disease. It includes information about the different types of stoma and the operations involved in their formation.

Act

Find out more about different types of bowel surgery, including the procedures mentioned in the article, from the All About Bowel Surgery website at http://tinyurl.com/yhj38jp.

Read more about bowel and bladder cancer on the Patient UK website at http://tinyurl.com/yh3zbwa and http://tinyurl.com/ygsrypq.

More information on ulcerative colitis and Crohn's disease can also be found on the Patient UK website at http://tinyurl.com/yh9j4jn and http://tinyurl.com/ykyguow.

Find out about support groups in your area for ostomists.

Evaluate

Are you now familiar with the different types of stoma and the operations that are carried out to form them? Are you aware which diseases may result in a stoma being necessary?

5 minute test

What have you learned?

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Practical Approach Test yourself in this everyday pharmacy scenario

Changes to clopidogrel dispensing

David Spencer, pharmacist at the Update Pharmacy, is drafting a note to send to local GP practices about a recent Drug Tariff change to clopidogrel, which appears to be causing some confusion among prescribers. He decides first to consult GP Mo Merali, to whose practice he supplies prescribing advice.

"Clopidogrel was moved to Drug Tariff Category A last month," David explains, "and I don't want there to be any misunderstandings when it's prescribed generically."

"I suppose I ought to know what Category A means, but could you explain it?" asks Mo.

David explains and Mo then says: "So we prescribe generically and the rest is up to you?"

"Sorry, it's not quite that simple, there is a complication," says David and goes on to explain.

Mo replies: "I can see what the problem is, but it could potentially push up our prescribing costs. Isn't there a way round it?"

"There is, but you may not want to do it," and David explains further.

"I see. I'd rather not take that on personally or within our practice, but couldn't the PCT do it?"

"It hasn't so far, but I suppose we could ask," David replies.

Questions

1. What is Drug Tariff Category A, and how does it relate to clopidogrel?
2. What is the "complication" mentioned by David?
3. What is the way of "getting round it"?
4. What should dispensing pharmacists do?

Answers

1. Two generic versions of clopidogrel (hydrochloride and besilate) are available in the UK. The basic Drug Tariff price of clopidogrel 75mg was based on that of Plavix (clopidogrel hydrogen sulphate) until December 2009 when clopidogrel was moved to Drug Tariff Part VIII Category A. The basic price is now based on a weighted average of prices of several suppliers and paid regardless of the make supplied.

2. Since 2008 Plavix has had a patent and marketing authorisation for the secondary prevention of acute coronary syndrome (ACS), a set of signs and symptoms compatible with acute myocardial ischaemia. Clopidogrel hydrochloride and besilate are licensed only for the prevention of atherothrombotic events in patients suffering from myocardial infarction, ischaemic stroke or established peripheral arterial disease, not for ACS. However, the European Medicines Authority considers that clopidogrel salts other than the hydrogen sulphate are also suitable for ACS.

3. Prescribing generic clopidogrel outside of the licensed indications ('off-label') for ACS. Prescribers may do this but in so doing accept personal liability for prescribing (as do pharmacists for dispensing). Prescribing off-label can also be authorised by a PCT for all its prescribers.

4. When a prescription is received for 'clopidogrel' pharmacists should ascertain whether the hydrogen sulphate is required. If it is they should supply and claim for Plavix, as they also must if clopidogrel hydrogen sulphate is ordered. Otherwise they can supply any salt of clopidogrel. Note that if a prescription calls for clopidogrel 75mg tablets (with no salt stated), regardless of any endorsement the NHS prescription services would reimburse Part VIII.

This article can help with these CPD competencies: **G1b, G1h, G1j, G1r, G1s, G5i, C5a.**
See http://tinyurl.com/68ox7b

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practical approach**

The last president

In the final months of the RPSGB, Steve Churton tells Chris Chapman about the highs and lows of his presidency and his legacy for the future professional body

"The greatest frustration has been the propensity of some members of the profession not to accept change"

Heavy is the head that wears the crown. Sat at his desk at RPSGB headquarters in Lambeth, Steve Churton may not be wearing his chains of office, but he's frank about the demands of his job. "It's 24/7," he says. "And relentless. I suppose I underestimated that. But I don't regret doing it."

Mr Churton will be the last president of the RPSGB. In April, the Society will be no more, devolving into regulator the General Pharmaceutical Council (GPhC) and leadership body the Royal Pharmaceutical Society. Now, months away from this endgame, and before he returns to Boots, he reflects on nearly two years at the helm of the professional body.

When he took the role, Mr Churton says he saw the Society as introspective and not focused on its members. "I saw an organisation which was not in an ideal position, in my view, to move forward. It became apparent to me that there would have to be some radical changes in terms of leadership style, values and member focus."

But change was no easy task, Mr Churton recalls. "I don't think it's easy for any organisation... I don't think there's been destructive resistance, though some people have had more difficulty accepting the change and actually changing."

The transition from the Society of 2008 to the leadership body of 2010 has not always been smooth. While Mr Churton says he acknowledged the upheaval would cause job losses and required a change in the Society's culture, he wasn't prepared for the resistance some pharmacists would have toward the new-look organisation. If he could have given himself one piece of advice, he says, it would be not to assume every pharmacist wanted a professional leadership body.

"The greatest frustration has been the propensity of some members of the profession not to accept change, embrace change, and understand it's going to happen... I didn't envisage that, so it was a surprise to me."

The animosity from some members has been, at times, intensely personal, and C+D has had to scrub some offensive comments from its website. There can be no doubt Mr Churton has attracted fierce criticism during his tenure as president, something he describes as "coming with the territory". But he concedes that expecting insults and attacks hasn't made them any less painful.

"I don't like seeing it, but you get immune to it... you can't help but be affected by very personal, bordering on libellous, comments, but you can't afford to be distracted.

"You just have to say, 'Well, that's how some people choose to make their point'. The underlying point is no less valid, but the way it's phrased is not helpful."

With the April deadline drawing close, the last president of the RPSGB believes his greatest achievement is having helped give the Society the strongest chance of life after spring 2010.

"It's a big achievement," he says. "I'm not taking that personally, no one person can do it. But if we get the Society to the point at the demerger that gives it the best chance in life going forward, that will be very satisfying for me."

Mr Churton believes he has succeeded in refocusing the Society back on its members. He hopes to be remembered as someone who changed the perception of the Society, and lists times when he felt members got behind the organisation as the high points of his term.

"The high was the charter vote. That was, I think, absolutely the right decision. The other high points were around the reaction of the profession to my [2009] British Pharmaceutical Conference speech and commitments, because that was a watershed moment when people started to understand and engage."

But Mr Churton is looking to his future, not his past accomplishments. He was asked by other members to apply for the role of chief executive of the professional leadership body, but instead has chosen to return to former employer Boots. He hopes this will bring more time with his family.

"I do want to get some personal life back," he says. "I'm like anyone else: you need balance in your life. And I probably haven't got that balance right out of necessity... when I go away from here, there's an opportunity to get a bit more in my life, a bit of normality."

So is the outgoing president seeking a return to the dispensary? "No," he laughs. "Going to work back at the sharp end is probably more of a challenge than what I've been doing in the past two years!"

Churton on...

... RESPONSIBLE PHARMACIST

"There's never a right time to implement something. Occasionally you have to bite the bullet and live with the consequences, and I don't think the consequences are as devastating as they've been made out to be."

... THE PDA

"I think the PDA is entitled to its opinion, everybody is... when organisations are critical, generally they're being critical for a constructive purpose. So I don't mind that; it's good to stop and think."

... BEING THE REGULATOR

"Someone has to be the regulator, and some would say it's a privilege, but it's been problematic... if you're talking about organisations speaking to members, you have to find the right tone of voice. And being the regulator has on occasion hindered that."

... HIS LEGACY

"To change the perception of the Society in the minds of members is something I'd like to be remembered for. God, it sounds like something to put on your grave."

The highs and lows of Steve Churton's reign

Jun 2008 Elected RPSGB president

Nov 2008 Launch of prospectus for the professional leadership body

Mar 2009 RPSGB special general meeting on who can call themselves a pharmacist

Jun 2009 Re-elected as president

Jul 2009 Pharmacists vote yes to changes to the Society's charter

Sep 2009 Mr Churton lays out a series of 100-day commitments at the BPC

Oct 2009 Society staff made redundant as it prepares for its de-merger in spring 2010

Apr 2010 Handover to new leadership body

Our commitments to you – the next 100 days

In September we outlined a series of commitments which set out what members can expect from the new body. To demonstrate these commitments we set ambitious targets to deliver within 100 days and have since made great progress.

This month, we launch some equally ambitious targets to deliver within the next 100 days. These include launching an information, advice and support service, ensuring access to physical or virtual Local Practice Forums and announcing our new vision for pharmacy which will inform the new Board's plans for the future.

Read more about the activities the Society will be delivering for members over the next 100 days.

For a full list of the commitments and updates on our progress on each of the specific activities, please visit www.pharmacypib.com

COMMITMENT 1: Actively listen to you and respond to your needs

We will...

- Make sure you are clear about the benefits to you as a member of the new Royal Pharmaceutical Society.
- Ask for your feedback and ideas through quarterly surveys, and share these with the National Pharmacy Boards to inform their priorities and plans.
- Make it easy for you to maintain your personal profile via our new website, so you can tell us how, when and what you want to hear.

COMMITMENT 2: Support your professional and personal development

We will...

- Launch our new information and advice service to support your practice, related legal and ethical queries, and your CPD.
- Recruit and train a team of expert reviewers ahead of the launch of our new CPD review service in April 2010.
- Deliver a CPD toolkit for Local Practice Forums to help them run great CPD events for you.
- Run further practice specific CPD webinar events following your feedback on the successful trials last year.

Listening to members and seeking our feedback has been the first step towards developing a successful leadership body. It is good to see that over the next 100 days the new body will continue to build on this commitment.

Kim Munro,
Lecturer in clinical pharmacy, Robert Gordons University, Aberdeen

COMMITMENT TO PHARMACY

COMMITMENT 3: Positively encourage professional networking and the sharing of knowledge

We will...

- Launch our new online network, enabling you to easily share knowledge and best practice with your colleagues.
- Make sure you have access to a physical or virtual Local Practice Forum.
- Pilot a Mentoring service, enabling you to benefit from the experience of others.

COMMITMENT 4: Effectively promote pharmacy in the development and delivery of healthcare policy

We will...

- Campaign to promote the patient safety, pharmacy workload, and economic benefits of whole patient-pack dispensing.
- Launch our vision for the future of pharmacy, which will inform the new National Pharmacy Board's strategic plans.
- Work with the Royal College of General Practitioners to develop recommendations which will improve working relationships between Pharmacists and General Practitioners.
- Promote the role of pharmacy by lobbying key civil servants and politicians from the main political parties in England, Scotland and Wales.

COMMITMENT 5: Improve the awareness and perceptions of pharmacy amongst the public and other healthcare professionals

We will...

- Identify and develop a network of local pharmacist spokespeople who can represent pharmacy in the media and at events.
- Establish a Media Advisory Board to build relationships with journalists.
- Target and independently measure consumer media coverage, and raise awareness of this activity in the profession.

COMMITMENT 6: Support those seeking advanced or specialist levels of practice

We will...

- Work with a wide stakeholder group to define and agree recognised levels for advanced and specialist practice.
- Put in place the structures to define the curricula and assessment criteria for these levels of practice.
- Work with you to promote the benefits of these nationally recognised levels to employers and commissioners.

COMMITMENT 7: Advance the science and practice research base for pharmacy and healthcare

We will...

- Provide support materials to enable you to build research capacity and the evidence base for pharmacy.
- Develop specific CPD support materials for those of you working in science and research.

I want to be able to learn from the experience of others and networking will help me do this. I am therefore pleased to see that the Society has already taken the first steps in helping build an online network for pharmacists and will be launching it in the next 100 days.

Finlay Royle,
University College London Hospitals, NHS Foundation Trust

The Society has already begun to raise the profile of pharmacy - we need one organisation with a clear message and authority to represent us. It is good to see that within the next 100 days, the new body will continue to build on its original commitment.

Paul Rutter,
Academic Pharmacist

C+D AWARDS 2010

In association with NPA National Pharmacy Association

The audit queen

The C+D Awards 2009 Pharmacy Technician of the Year talks to **Matthew Valentine**

Lynn Kennywell says her varied career history, involving work for community pharmacies, hospitals, PCTs and dispensing doctors, is to thank for the freedom she is afforded in her current role at Dean & Smedley.

Now nicknamed 'The Audit Queen' by colleagues, last year's C+D Pharmacy Technician of the Year has been able to identify issues, research them and initiate new practices for the company as a result. Her work has led to new SOPs being adopted across the company, and has an impact in other pharmacies, too.

While some would take the opportunity for a well-earned rest after completing a large project, such as the warfarin audit for which she received her C+D Award (see below), Ms Kennywell decided to begin another one almost immediately.

"I've been working on the Rapid Response Report for opiates," she says. This has involved a substantial round of background reading, and research with the local PCT about the most widely prescribed opiates in the area, followed by an audit of Dean & Smedley's 13 branches.

"I've looked at dosing, inappropriate dosing, accurate dosing and if there have been any interventions," says Ms Kennywell.

Along with her research on opiates, she has also found time to work on developing an asthma clinic, which should keep her busy into the early part of 2010.

Being able to see the bigger picture of how her work can be of use to patients and the company appears to be a key element in the process that Ms Kennywell uses to gain the co-operation of other health agencies, as well as her own colleagues within Dean & Smedley. "I think it's because I have such a broad experience, because I've worked all over the place," she says.

Her own commitment to the job at hand is also important. As well as taking part in any training available, Ms Kennywell spends five or six hours every week doing additional reading at home as research for the projects she works on. "I wouldn't have time at work," she says. "Yesterday I spent three hours reading about asthma."

It is a good job that Ms Kennywell isn't the kind to put her feet up, as her proactive nature means it is unlikely that she will benefit from any spare time at work in the near future. She is already looking for a new outlet for her auditing talents, and has her eye on the use of lithium.

Entry for the **C+D Pharmacy Technician of the Year 2010** category is now open. Go to **www.chemistanddruggist.co.uk/awards** for full entry details, hints and tips, to download an entry form or to enter online.

Alternatively, you can enter using the form inserted into this issue of C+D.

Name
Lynn Kennywell (pictured above with C+D Projects Director Patrick Grice)

Pharmacy
Dean & Smedley, Ashby-de-la-Zouch, Leicestershire

Award won
Pharmacy Technician of the Year 2009

Award entry
An audit of warfarin use

Dream holiday destination
Lapland. Ms Kennywell would like to see Father Christmas at work with his elves

Cats or dogs?
Wagging tails swing it for Ms Kennywell

Paracetemol or ibuprofen?
Paracetamol gets Ms Kennywell's vote

How Lynn won the C+D Pharmacy Technician of the Year Award 2009

Where did the idea for the service come from?
Lynn Kennywell won her C+D Award for her work in auditing warfarin use. "We'd heard of problems with people overdosing on warfarin, and thought it would be good to target that area," she says. A period of research followed: "I read everything I could find about warfarin, then I went to visit the local hospitals at Burton and Derby and went to anticoagulant clinics at local GP surgeries."

What challenges had to be overcome?
Making sure that other health professionals supported the audit project was a vital element in its success. "We spoke to the consultants at Burton Hospital and they were very interested in what we were trying to do," says Ms Kennywell. She says that local GPs have been supportive and helpful as well.

How did the service take shape?
The ensuing project saw patients asked about their warfarin use, and the information they had been given about possible interactions with foods and other drugs. The information gathered was recorded on special forms. A company-wide audit of warfarin patients then looked at the number of interventions by pharmacists, and logged AF and DVT indications, along with doses and INR targets. "Every warfarin prescription we handle now is logged; it has become a company SOP," says Ms Kennywell.

What was the wider impact of the project?
The impact of her work has not stopped there. Since Ms Kennywell's project was highlighted by winning her C+D Award, it has been emulated by technicians from other companies. "I have spoken to a lady who read an article I wrote about the warfarin audit after winning the C+D Award. She had implemented it in her pharmacy too," says Ms Kennywell. "It's absolutely brilliant that somebody else has taken it on board."

How to write a winning award entry

Top tips on writing an entry designed to catch a judge's eye, from **Max Gosney**

Guests at the C+D Awards 2009 enjoyed a glittering black tie event at London's Grosvenor House Hotel

Fancy your chances? Enter using the entry form inserted in this issue of Chemist+Druggist

1. Sell, sell, sell

Entries should really sell the person or service they are describing – judges will see lots of entries and you need to make yours stand out. Don't be a shrinking violet. For example, if you've launched a cardiovascular screening service and spotted a patient with high blood pressure, then sell it to the judge as a potential life saving intervention, not just a regular CV check up. Outline your successes and why they mattered. Then expand on each one and add details wherever possible.

2. English lessons

The entry form should read like a high paced thriller, not the write-up of a school science experiment. Every word counts. Keep sentences short and punchy. You can always add lots of supporting documents and testimonials, but if the initial 500 words don't sell your entry, the judges will never get that far.

Use active verbs to inject interest. For example: "A screening service for patients aged over 60 years old with higher associated risk of developing cancer was initiated by the pharmacy manager and members of the pharmacy team," can become: "The pharmacy team launched a trail-blazing cancer screening test for elderly patients."

Remember, however, to reinforce the active language with factual evidence behind your claims, like this: "The pharmacy team launched a trail-blazing cancer screening test for elderly patients. In just six months staff spotted five patients later diagnosed with cancer after referral to their GP."

3. Read aloud and refine

Good cooks taste their food before they serve it. That way if the sauce is too bland they can season it before it reaches the table. The writer's equivalent is reading your article out to make sure it actually makes sense before submitting the final copy. Print a draft version and read it aloud. If there are bits that are hard to read or confuse you then imagine how a judge might feel. The more you do this, the more polished your final entry form will be.

4. Get it done early

Don't sail too close to the wind on deadlines. The earlier you have the copy written, the more chance there will be to check over for mistakes and polish the final piece. If you're rushing, the quality of the entry could suffer. An idea might be to set staff a soft deadline, one or two weeks ahead of the actual awards entry deadline. This way you get to look over and refine your entries.

Spot the award-winning entry

Congratulations, you've been appointed to the prestigious post of C+D Awards judge. Before the champagne on the big night, you face the task of judging hundreds of entries. Imagine you're Simon Cowell. You don't have much time and you're looking for something that makes an instant impression, so which one of the following two entries has the X Factor?

Entry A

Rob Roy joined Bloggs Pharmacy chain in 1997. Rob works really hard and is often asked for in person by the customers. A screening service for patients aged over 60 years of age with higher associated risk of developing cancer was researched and instigated by Rob and the members of his pharmacy team. Rob is very well received by the members of his pharmacy team. Medicines use reviews is an area that Rob considers to be of necessary importance and his team will endeavour to complete as many as possible. Rob has ensured the pharmacy is kept highly organised, reducing stock holding and ensuring date checking and other standards are adhered to in the professional manner required. During the summer, one man suffering back pain passed blood when he used the toilet at the pharmacy. He was referred after a consultation with Rob to his local GP, who then diagnosed the man with early prostate cancer.

Entry B

Since joining Bloggs Pharmacy chain, Rob Roy has researched, launched and delivered a service to protect his community in Godbury against the UK's biggest killer. When Rob found a shocking one in 10 residents had grandparents with cancer he vowed to make a difference. He inspired his pharmacy team to launch a trail-blazing cancer screening service for the elderly. In just six months staff spotted five patients later diagnosed with cancer after referral to their GP. But it's not just elderly patients who have Rob to thank for their wellbeing. One 30-something father of three owes his life to Rob. When he used the pharmacy toilet the man was distressed to see blood in his urine. Rob swung into action. He persuaded the patient to come into his consultation area and urged him to visit his GP for a check up. He was later diagnosed with prostate cancer. The GP was able to fast track the man for life saving treatment – had the cancer gone undetected for another few months he may not have survived. Thankfully for him and many others in Godbury there is a guardian angel by the name of Rob Roy to protect them.

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Postscript...

Last year was Boots' 160th birthday and, to celebrate, Postscript thought it would take a quick trip through time to see what impact the company has had on the UK...

Boots, Nottingham, 1885. Inset – Jesse Boot

1849

It all started with a pair of Boots: John and Mary Boot open up a herbalist's store in Nottingham. John Boot died in 1860, leaving Mary in charge. Son Jesse later takes over the reins.

1884

Boots spreads out from Nottingham, through Yorkshire and Lincolnshire. The company also finally decides to recruit a pharmacist to help run things.

1899

Boots the library? The company branches out to appeal to bookworms, launching a subscription library that swelled to 35 million books being exchanged. It even gained the company a cheeky plug in a John Betjeman poem (in Westminster Abbey, in case you're wondering).

1906

"It is one of my greatest joys in life that I am able to stretch out a helping hand to so many young girls" – Florence Boot. Mrs Boot was big on helping staff, ordering them to be given hot cocoa every morning when she found out many were skipping breakfast to come to work.

1914-18

The first world war rages, but the health-conscious soldier stuck in the trenches can still get his medicines: Boots sends out mail order catalogues to the troops.

1934

The company decides to try something radical: a five-day working week. The move "has tended to a diminishment of ill-health and absenteeism and has had an inspiriting effect", a Boots review says.

1935

Boots launches its No7 cosmetics range. And for those of you wondering what happened to the first six, Postscript can now reveal they never existed. "The number 'seven' has long signified perfection," read a Boots pamphlet when the range was launched.

1944

The company plays its part in the second world war, producing new wonder drug penicillin to save the lives of troops.

1951

Boots finds itself in hot water with the RPSGB, when it decides to let customers pick medicines off the shelf and pay at a till for the first time. After a legal tussle in the courts and a landmark ruling, Boots wins.

1969

Boots discovers ibuprofen. No, really – a team led by Dr Stewart Adams cracked one of the most common analgesics in use today, which became available over the counter in 1983.

2006

Boots merges with Alliance UniChem, creating international company Alliance Boots.

2009

Boots celebrates its 160th birthday. Alliance Boots employs more than 115,000 people in more than 20 countries and owns almost 3,000 pharmacies.

Boots, Romford, Essex, 1972

Boots, Westfield Shopping Centre, 2010

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1. Burgess IF, Brown CM, Lee PN, Pharm Jnl 2008, 280; 371-375
2. IRI Unit Sales 12 w/e 31 Oct 09